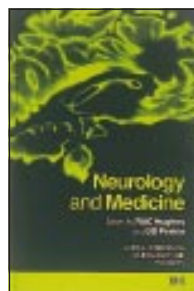


reviews

BOOKS • CD ROMS • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

Neurology and Medicine

Eds R A C Hughes, G D Perkin



BMJ Books, £45, pp 430
ISBN 0 7279 1224 0

Rating: ★★★

About 20% of acute medical admissions to district general hospitals are for neurological problems, often in the context of other medical conditions. Their management may be complicated: neurology is one of those subjects in which general physicians often feel least comfortable, and in many parts of the country neurologists remain thin on the ground and may themselves have limited experience of uncommon illnesses in specialties that are

not their own. *Neurology and Medicine*, the latest in a series of books from the BMJ covering the investigation and management of neurological conditions, aims to cater for both groups.

Such an ambitious foray into the borderland between two clinical specialties runs the risk of not being user friendly to either group, but the editors have, for the most part, managed to overcome this difficulty by having at least two authors (drawn from various parts of the world) for each chapter, one a neurologist and the other a specialist in the other subject. The result is a well referenced text that addresses the clinical features, diagnosis, and basic management of the conditions discussed, in addition to updating readers on the current state of knowledge regarding the underlying pathophysiological mechanisms. It is sufficiently readable to be read straight through—and in this respect will be particularly useful to those training in neurology—but it will also, I suspect, be used as a handy reference for those asked to see patients with unusual conditions on the wards.

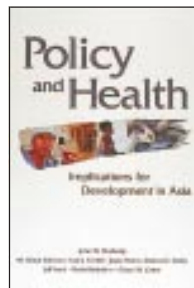
The book is not encyclopaedic, nor does it claim to be. A subject with such a wide remit poses organisational difficulties. Thus, some chapters cover the neurological conditions associated with disorders of specific organs (such as bone marrow, heart, liver, kidney), while others concentrate on symptoms, such as chorea and dystonia, in acquired systemic disorders or the neurological complications of such conditions as diabetes and pregnancy. Notable omissions include the neurological complications of substance misuse, those related to various infections, and neurological syndromes associated with neoplasia.

A book of this size cannot cover most of the conditions in great detail. Rather, it will serve to draw attention to the spectrum of neurological disease in general medicine and to emphasise the need for cooperation between neurologists and general physicians in the management of patients with these challenging conditions.

Yvonne Hart consultant neurologist, Atkinson Morley's Hospital, London

Policy and Health: Implications for Development in Asia

John W Peabody, M Omar Rahman, Paul J Gertler, Joyce Mann, Donna O Farley, Jeff Luck



Cambridge University Press,
£30, pp 464
ISBN 0 521 66164 1

Rating: ★★

Dramatic changes have occurred in the fields of economics and health in recent years—the AIDS crisis in particular has highlighted the interactions between the two. However, there are hardly any books and very few recent articles showing how policy that affects economics also affects health.

This book's title suggests that it should be ideal reading for a politician or a senior health official trying to find out which health

policies to implement in Asia. Starting with "The role of governments in the health sector," the book covers evidence based policy, prioritisation of medical interventions, financing and allocation of resources, equity, and health behaviours and ends with "Implementation of policy objectives." References occupy nearly 80 pages, and the index shows the names of most Asian countries, from Kazakhstan to Fiji, while a quick dip into the chapters shows boxes listing examples from individual countries. The advance praise for the book quoted on its back cover is lavish, and the foreword states that the book places "international experience at the disposal of national decision-makers and those who advise them." Both are always in need of information, both often do not know where to find it, and both have little time to digest it.

However, I'm afraid they are in for a disappointment if they turn to this text for help. At over 400 pages, this is no quick read, and its style is vague, sometimes to the point of unintelligibility. It is thorough, scrupulously recording "Policy implications" in the one page summary at the start of each chapter. But statements such as "policies ... need to be evaluated," "implementing social insur-

ance ... requires that conditions be right," and "policy makers should ... plan and evaluate ... strategies at a pilot level" are hardly groundbreaking. The chapter on prioritisation relies heavily on disability adjusted life years (DALYs), which seem to be implicitly accepted (despite a rather perfunctory discussion of objections). The chapter on financing makes particularly heavy reading for the non-economist. Only half of the boxes giving examples from individual countries actually refer to a country of Asia, and about a third of those that do are pretty general: individual stories of success or failure would have had much greater impact.

For academics and researchers, this book is probably a valuable resource, but the authors have missed an opportunity to write a useful guide for those who have to make and advise policy in the daily hurly-burly. A less ambitious series of texts concentrating on one country or on a group of countries with similar problems—rather than the more than 40 very different countries listed here—and written in a more approachable manner would have been preferable.

Michel Thuriaux former medical officer (epidemiologist), Communicable Diseases, World Health Organization, Geneva, Switzerland

Reviews are rated on a 4 star scale (4=excellent)



The psychokiller strikes again

ER, Channel 4, Wednesday 19 April at 9 pm

E*R* (*Emergency Room*), the US television drama of high adrenaline medical heroics, has blazed its way into a sixth series. It has undoubtedly captured the public imagination, with its strong characters, uneasy tensions, and frenetic trauma calls. It presents highly positive images of healthcare professionals, which is perhaps why the *BMJ* and *Nursing Times* put two *ER* characters on the cover of their recent joint issue. The programme reaches the masses. This year, in the week starting 18 January, it was watched in 21 million out of a possible 99.4 million US households.

In Britain Channel 4 screened two extraordinary episodes on 19 April, which caused much public excitement, sadness, and even grief. The country watched in horror the double stabbing of medical student Lucy and resident Dr Carter.

In the first episode we saw Lucy working up the case of a young married man, Paul, who had presented with headaches. Carter offers minimal supervision. When the man becomes disoriented she carries out a lumbar puncture while Carter holds him down. All examinations and tests are normal, and when Paul's college friends describe a recent increase in bizarre and

suspicious behaviour a psychiatry consult is requested. The psychiatrist is busy, of course, so Paul remains untreated in a secluded side room. The episode ends with Paul's unprovoked and vicious assault on the medics. Carter falls to the floor to see Lucy bleeding to near death under the patient's trolley.

In the second episode (can we really handle more of this in one night?) we see the brutal resuscitation and harrowing surgery of both victims. In the midst of this clinical chaos Paul returns. He had escaped the hospital, but was hit by a car. Although Paul is clearly psychotic and has life threatening injuries, consultant Dr Weaver cannot bring himself to treat him and hands over his care to a colleague. Lucy awakes postoperatively, and, true to form, she diagnoses a pulmonary embolus in herself and then dies. Carter survives.

This was undoubtedly a dramatic and powerful storyline. But, after seeing the episodes, we became concerned about *ER*'s portrayal of mentally ill people. Did it only ever show them as violent and dangerous? We went back and watched 22 consecutive episodes to see how psychiatric patients were represented.

In these episodes, there were 28 patients with psychiatric problems, most often substance misuse. Six were psychotic. One man smashed his car with a baseball bat because of the "demons" telling him to harm his wife. A woman who thinks she is a bird is brought into the emergency room in a huge birdcage. Haloperidol is advised before they get bolt cutters to release her. A woman masquerades as a doctor, but is stalking a male staff member as part of a delusion of erotomania.

Five patients deliberately harm themselves, mostly through destructive acts such as cutting. One man encourages another to drill a hole in his forehead, and a depressed



Lucy and Carter, victims of *ER*'s violent "psychokiller"

woman threatens to harm others. A man with mental health problems shoots his wife and children, and a similar patient kills a police officer.

Four children are shown with attention hyperactivity disorder, and four adults with post-traumatic stress disorder, one of whom becomes aggressive when recollecting the traumatic experiences. One child kills another and there is a suggestion that he has psychological problems, since a psychiatry consult is requested. The one example of suicide is an extreme situation, in which a man first rapes a comatose patient and then hangs himself.

These examples suggest to the audience that mentally ill people are nearly always destructive, either to themselves or others. The dominant theme is one of threat. While it is true that emergency psychiatrists do see violent patients, we feel that *ER* over-represents this danger. More importantly, it fails to offer an empathic view of the distress that mental illness causes to sufferers. We fear that many viewers will share Dr Weaver's revulsion at the "psycho" who killed Lucy and maimed Carter. Even depressed and suicidal patients are shown harming others. The series, in making such a strong association between psychiatric illness and violence, is following established trends in television news, drama, and the tabloid press. It is adding to the process of stigmatisation by the media.

These are strong stories with harrowing images, and they totally fail to offer a sympathetic view of people with mental health problems. It is too late for us to object formally to the producers, and we are not suggesting censorship. The irony here is that this series achieves a high degree of realism when it deals with medical and surgical emergencies. We wish that it would offer the same degree of accuracy in its portrayal of psychiatry. Where are the cases in which patients are helpfully supported through the terror and distress of their acute illness?

The proportion of homicides committed by mentally ill people in Britain has fallen annually since 1957. The challenge now is to propagate some positive media stories, creating more accurate images to capture the public imagination.

Rita Mairead Condren research registrar, St Vincent's Hospital, Dublin
Peter Byrne consultant psychiatrist, Kent



WEBSITE OF THE WEEK

Exploring the genome This week the *BMJ* reviews the progress made to date on the human genome project (p 1223). It is the power of information processing technology that has made such achievements even thinkable; and that power is also used to allow instantaneous communication of results to a global network of collaborating (and competing) researchers. The starting point for exploring their work is www.ncbi.nlm.nih.gov/genome/seq/.

Just contemplating the volume of data that the site has to serve now takes your breath away; when the sequence is complete it will be truly awesome. With such demands it is fitting that the site's design clothes its content in a user interface of beguiling simplicity. On a web choked with gratuitous graphics, this site uses them entirely appropriately. The site is organised by chromosome. Each is linked to a page which describes the current progress with mapping its genes and shows a more detailed graphic of the chromosome. Areas already sequenced are marked with red and orange bands. Click on a band and up come the genes themselves, represented as vertical blue lines. Pick a line, and the gene sequence itself, in all its ggccgtgaatt glory, downloads to your browser. (Tourists should not do this too often: 200 kilobases generates a bandwidth-choking file of more than 200 kilobytes: so look for a short one). If you have a gene sequence to identify, the site's BLAST feature (www.ncbi.nlm.nih.gov:80/BLAST/) enables the search to be made in reverse. A comprehensive review of this site's informational features requires a PhD in molecular genetics. Those of us not so endowed might begin with a glossary (www.ornl.gov/hgmis/publicat/glossary.html) and a primer in human genetics (www.bis.med.jhmi.edu/Dan/DOE/intro.html).

Douglas Carnall
BMJ
dcarnall@bmj.com

PERSONAL VIEW

The sins of expertness and a proposal for redemption

Two decades ago I was an expert on the subject of compliance with therapeutic regimens. I enjoyed the topic enormously, lectured internationally on it, had my opinion sought by other researchers and research institutes, and my colleagues and I ran international compliance symposiums and wrote two books, chapters for several others, and dozens of papers about it. Whether at a meeting or in print, I was always given the last word on the matter.

It then dawned on me that experts like me commit two sins that retard the advance of science and harm the young. Firstly, adding our prestige to our opinions gives the latter far greater persuasive power than they deserve on scientific grounds alone. Whether through deference, fear, or respect, others tend not to challenge them, and progress towards the truth is impaired in the presence of an expert. The second sin of expertness is committed on grant applications and manuscripts that challenge the current expert consensus. Reviewers face the unavoidable temptation to accept or reject new evidence and ideas, not on the basis of their scientific merit, but on the extent to which they agree or disagree with the public positions taken by experts on these matters. Sometimes this rejection of "unpopular" ideas is overt (and sometimes it is accompanied by comments that devalue the investigators as well as their ideas, but this latter sin is by no means unique to experts). At other times, the expert bias against new ideas is unconscious. The result is the same: new ideas and new investigators are thwarted by experts, and progress toward the truth is slowed.

Chastened by these realisations, in 1983 I wrote a paper calling for the compulsory retirement of experts and never again lectured, wrote, or refereed anything to do with compliance. I received lots of fan mail about this paper from young investigators, but almost none from experts. I repeated my training in inpatient internal medicine, spent much more time in clinical practice, and applied my methodological skills to a new set of challenges in appraising and applying evidence at the bedside.

As before, the experience was challenging and exhilarating. Working with gifted colleagues, first at McMaster and later in Oxford and throughout Europe, I became

an expert in an old field with a new name: evidence based medicine. Because interest in these ideas was so great, especially among young clinicians around the world, my writing and editing was published in several languages, and when I was not running a clinical service I was out of town demonstrating evidence based medicine at the bedside and lecturing about it (over 100 times in 1998).

Although acceptance of my views was not universal, once again my conclusions came to be given too much credence and my opinions too much weight. And newcomers to the field who regarded me with affection faced an additional deterrent to challenging my expertness: they feared hurting my feelings as well as earning my disapproval. Two clinical signs confirmed that I was once again an expert. The first was the reception of an honorary degree and the second bears my name: "Sackettisation," defined as "the artificial linkage of a publication to the evidence based medicine movement in order to improve sales."

As before, I decided to get out of the way of the young people now entering this field, and will never again lecture, write, or referee anything to do with evidence based clinical practice. My energies are now devoted to thinking, teaching, and writing about randomised trials, and my new career is as challenging and exhilarating as its predecessors.

Is redemption possible for the sins of expertness? The only one I know that works requires the systematic retirement of experts. To be sure, many of them are sucked into chairs, deanships, vice presidencies, and other black holes in which they are unlikely to influence the progress of science or anything else for that matter. Surely a lot more people could retire from their fields and turn their intelligence, imagination, and methodological acumen to new problem areas where, having shed most of their prestige and with no prior personal pronouncements to defend, they could enjoy the liberty to argue new evidence and ideas on the latter's merits.

But there are still far more experts around than is healthy for the advancement of science. Because their voluntary retirement does not seem to be any more frequent in 2000 than it was in 1980, I repeat my proposal that the retirement of experts be made compulsory at the point of their academic promotion and tenure.

David L. Sackett director, Trout Research and Education Centre at Irish Lake, Markdale, Ontario, Canada

SOUNDINGS

A medical error

In the dying days of the first half of the last century, when ward sisters wore starched veils and hospital walls were painted green, an intern 10 days out of medical school was summoned in the middle of the night to restart a clogged intravenous drip. This was done in those days by injecting 3.8% of sodium citrate, a procedure that doctors but not nurses were allowed to undertake.

Sleepily the intern made his way to the medical floor. A young nurse handed him the ampoule; the doctor pushed its contents into the plastic tube; the patient made an awful gurgling sound, turned blue, and stopped breathing, her head slumping on her chest.

By this time the nurse had left the floor. The young doctor stood transfixed, panic struck, uncertain what to do, then ran to the phone to get help, but found all lines were busy or not answering. He returned to the patient, who at that moment gave a deep snort, turned pink, and began to breathe normally.

All this happened before the "error prevention movement," so ably covered in a recent issue (18 March). Since then potassium chloride ampoules have been mercifully removed from medical floors, and there has been much talk about developing systems to prevent the most blatant errors in the way it is done in aviation and other industries. There has also been much discussion about reporting errors, an idea that populist politicians have quickly seized on, leading to the suggestion of mandatory reporting by hospitals to central, government run agencies or accrediting bodies.

Although such reporting should ideally be voluntary and non-punitive, in practice this is unlikely to end up being so. Even today in many hospitals such an intern might have been fired or severely disciplined for his or her mistake, the nurse reprimanded, the hospital and the doctors sued for malpractice. Many ethicists, however, would contend that none the less the doctor has an obligation to disclose his or her mistakes, that this particular intern should have told everybody, or at least his superior.

It seems, however, that this particular intern was possessed of a highly developed sense of self preservation. I am told that he put the ampoule in question in his pocket and walked away from the ward. So the question arises, what would you have done under the same circumstances, and what would you do now?

George Dunea attending physician, Cook County Hospital, Chicago, USA

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email editor@bmj.com